SUPPLEMENTAL REPORT
OF THE
2010
HEALTH INSURANCE MARKET
IN
NEW HAMPSHIRE

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Prepared by the New Hampshire Insurance Department
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By law, the Insurance Commissioner is authorized to prescribe the format and content of financial and other reports filed by insurers licensed in New Hampshire. The data submitted in the Supplemental Report is critical to understanding and evaluating the New Hampshire's health insurance market. The data are collected annually, and this report is based on activity during the calendar year 2010.

Summary findings are presented first, followed by more detailed analyses. For those who are not familiar with the data collected in the Supplemental Report, you are encouraged to start with the Supplemental Report History, Data Collected, and Data Notes sections at the end of the report.

Presented below are summary statistics about insurance data submitted to the NHID. These data include members insured and members covered by self funded policies.

SUMMARY STATISTICS

- Large Group = 480,852
  - 75% of all members
  - 29% fully insured (140,920)

- Small Group = 112,756
  - 18% of all members
  - >99% fully insured
  - 7,138 in group of one

- Non-Group = 45,480
  - 7% of all members
  - 100% fully insured

- Total premiums and premium equivalents = $3,243,957,916
- Total claims = $2,812,206,507
- Average loss ratio = 86.7%
- Average number of members insured = 639,088
- Average member premium per month:
  - Large Group $445
  - Small Group $402
  - Non-Group $246

HIGH DEDUCTIBLE HEALTH PLANS

- Percent of members in an IRS defined High Deductible Health Plan (HDHP) = 12%

SELF FUNDED PLANS

- Percent of members covered under employer self-insured plans:
  Large Group = 71%
  Overall = 53%

DEDUCTIBLES

Most common deductible amounts, based on percent of covered members:

- $0 – 37%
- $500 – 9%
- $1,000 – 10%
- $1,500 – 4%
- $2,000 – 8%
- $2,500 – 4%

CO-INSURANCE

Most common co-insurance amounts, based on percent of members:

- 0% co-insurance - 66%
- 10% co-insurance - 9%
- 20% co-insurance - 21%

CO-PAYS

Most common co-pay amounts, based on percent of members:

- $0 – 19%
- $5 – 7%
- $10 – 14%
- $15 – 8%
- $20 – 19%
- $25 – 11%

DETAILED ANALYSES

HIGH DEDUCTIBLE HEALTH PLANS (HDHPs)

Data are identified for members enrolled in a high deductible health plan based on whether the policy qualifies as an IRS defined high deductible health plan during the calendar year 2010. In 2010, the IRS definition included policies with a minimum deductible of $1,200 for an individual and $2,400 for a family.

The overall percentage of members in a HDHP is 12 percent. This represents a slight increase from 2009, with the highest penetration still in the non-group market segment. There were small shifts to the HDHP penetration rate within each market segment, with increases in the group segment and a slight decrease in the non-group segment.

As with all tables shown in the report, both self-insured and fully-insured members are included in the large and small group columns. Self/Fully-insured columns are NOT mutually exclusive from the Large/Small/Non-Group columns. Percentages are always determined for data within each column. Tables from 2010 and 2009 are below.

2010

HDHP	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
No	89%		94%	82%		91%	84%	75%
Yes	11%		6%	18%		9%	16%	25%
Total Members	639,088		340,838	298,250		480,852	112,756	45,480

2009

HDHP	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
No	92%		97%	87%		94%	87%	73%
Yes	8%		3%	13%		6%	13%	27%
Total Members	542,829		256,757	286,073		406,362	106,821	29,647

Observations:

- HDHP overall penetration rate is slightly higher in 2010 than in 2009.
- HDHP penetration rates increased in all market segments except for Non-group.

AVERAGE PREMIUMS

The average premium is a calculated rate, based on the total premium amount received by the carrier/TPA, divided by covered member months. Categorizations by market segment (non-group, small group, large group), insurance status (self-insured, fully-insured), and plan type (HMO, POS, PPO, EPO, Indemnity) are important given that many of the New Hampshire insurance laws differ among the classifications shown. For example, carriers are allowed to adjust individual rates for differences in age, health status, and tobacco use. In small group, rates may be adjusted for differences in age, number of employees enrolled, and type of industry. In large group, the rates issued to an employer may reflect historical claim experience of that employer group. Since the premiums are aggregated across carriers, average premium values will not represent the actual premium charged for a particular policy, but will reflect the aggregation of the benefit designs, product pricing strategies, and rating factors utilized by all carriers. The average premiums per member per month by market category and plan type are shown below.

			Self-Insured*			**Fully-Insured**	
Market Category	**Plan Type**		**Members**	**Avg Premium**		**Members**	**Avg Premium**
Large Group	HMO		116,569	$486		75,292	$439
	POS		67,579	$451		4,806	$580
	PPO		147,549	$422		54,207	$413
	EPO		2,050	$308		6,583	$307
	Indemnity		6,187	$560		31	$793
Small Group	HMO		602	$420		69,225	$410
	POS		27	$542		5,724	$371
	PPO		276	$373		18,679	$415
	EPO		No Membership Reported			16,882	$371
	Indemnity					1,341	$340
Non-Group	HMO		No Membership Reported			9,355	$179
	POS					No Membership Reported	
	PPO					33,155	$269
	EPO					71	$468
	Indemnity					2,899	$201
Total			**340,838**	**$451**		**298,250**	**$391**

*A premium equivalent is provided for self-insured policyholders. Please see the Data Notes section for additional information regarding the calculation methodology.

Observations:

- Most people are covered by HMO plans in the group market while most people are covered by PPO plans in the non-group market.

- HMO average premiums in the group market ranged from $410 to $486, compared to only $179 in the non-group market. No POS membership was reported in the non-group segment.

Average Premium and Benefit Richness

Benefit richness is measured using an actuarial value that represents the cost of providing benefits when compared to a hypothetical standard benefit package. For example, if the standard benefit package covers a range of medical services including ten physical therapy (PT) visits, and is compared to a policy that has the same benefits except coverage for only five PT visits, then the difference in the actuarial value would reflect the difference in the cost of providing coverage for an additional five PT visits.

The computed actuarial value of the standard benefit package allows the NHID to compare the value of different benefit packages that do not cover the same services at the same level. Using the example above with five PT visits that are fully covered, the value of that plan can be compared against another plan that covers ten PT visits with a fifty percent co-insurance for each visit. If both benefit packages have the same premium, which is the better value?

The actuarial value is a calculation that identifies the difference in the actual cost of providing one insurance policy versus another. For example, if the insurer pays fifty percent of ten visits, it might be assumed that the value of a plan is equal to a plan on which the insurer pays the full amount of five visits. In fact, the actuarial value may be different because a member may utilize more than five visits infrequently, so that the cost to the carrier of providing five visits with no co-insurance is greater than proving ten with cost sharing.

The standard benefit plan that carriers are required to use to calculate the actuarial value is based on the health benefit plan developed by the New Hampshire small employer reinsurance mechanism. Given that the benefit plans differ by plan type, comparisons can only be made within the same plan type category (e.g. only compare HMO benefit richness values to other HMO values).

Below is a comparison table of average premiums and actuarial values between the small and large group markets and the non-group market.

		Self-Insured*			Fully-Insured		
Plan Type	Market Category	Members	Avg Premium	Benefit Richness	Members	Avg Premium	Benefit Richness
HMO	Large Group	116,569	$486	0.91	75,292	$439	0.73
	Small Group	602	$420	0.86	69,225	$410	0.68
	Non-Group	No Membership Reported			9,355	$179	0.94
POS	Large Group	67,579	$451	0.82	4,806	$580	1.03
	Small Group	27	$542	0.98	5,724	$371	0.79
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	147,549	$422	0.79	54,207	$413	0.66
	Small Group	276	$373	0.72	18,679	$415	0.59
	Non-Group	No Membership Reported			33,155	$269	0.23
EPO	Large Group	2,050	$308	0.73	6,583	$307	0.61
	Small Group	No Membership Reported			16,882	$371	0.59
	Non-Group				71	$468	0.69
Indemnity	Large Group	6,187	$560	0.92	31	$793	0.94
	Small Group	No Membership Reported			1,341	$340	0.16
	Non-Group				2,899	$201	0.25
Total Members		340,838			298,250		

*A premium equivalent is provided for self-insured policyholders. Please see the Data Notes section for additional information regarding the calculation methodology.

Observations:

- For the HMO products, the average premium for fully-insured large group is higher than for fully-insured small group, but the difference can be explained by the weaker benefits in the small group market.
- For HMO large group, the average premium for self-insured is 11 percent greater than the value of the average premium for fully-insured, but the value of the self-insured benefits is about 25 percent greater than the fully-insured benefits.
- The self-insured large group POS premiums are about 22 percent less than the fully-insured large group POS premiums, which is roughly equivalent to the difference in benefit value.
- For PPO large group, the self-insured premium is 2 percent higher than the fully-insured premium; however, self-insured benefits are 20 percent higher. The average premium for PPO large group is similar to that of small group; however the benefit value for large group is 12% greater.
- Policies under the Indemnity plan type vary extensively with respect to benefit richness and premiums.

The table below provides comparative information for 2009 and 2010 data. The "Change in Value" reflects the total overall change in both premiums and benefit richness. If premiums go up by five percent and benefit richness goes down by five percent, the total change in value is equal to negative ten percent. No adjustments are made for inflation or for changes in the underlying risk of the members (due to factors such as age, health status, etc.), which may also be contributing factors to the change in average premium.

		Members		Avg Premium*		Benefit Richness		
Plan Type	Market Category	2009	2010	2009	2010	2009	2010	Change in Value
HMO	Large Group	185,881	191,861	$399	$468	0.85	0.83	-20%
	Small Group	63,239	69,827	$400	$410	0.74	0.68	-10%
	Non-Group	388	9,355	$423	$179	1.01	0.94	51%
POS	Large Group	78,859	72,385	$402	$460	0.82	0.83	-13%
	Small Group	2,883	5,751	$471	$372	0.84	0.79	15%
	Non-Group	No Membership Reported						
PPO	Large Group	124,276	201,756	$378	$420	0.69	0.75	-2%
	Small Group	26,254	18,955	$378	$415	0.61	0.59	-13%
	Non-Group	26,688	33,155	$264	$269	0.24	0.23	-8%
EPO	Large Group	8,893	8,632	$337	$308	0.78	0.63	-10%
	Small Group	14,203	16,882	$382	$371	0.76	0.59	-20%
	Non-Group	25	71	$530	$468	0.74	0.69	4%
Indemnity	Large Group	8,452	6,217	$540	$562	0.91	0.92	-3%
	Small Group	241	1,341	$724	$340	0.97	0.16	-30%
	Non-Group	2,546	2,899	$177	$201	0.34	0.25	-39%

*A premium equivalent is provided for self-insured policyholders. Please see the Data Notes section for additional information regarding the calculation methodology.

Observations include:

- HMO Large Group represents 30 percent of the membership, and the value of the insurance for these members dropped by about 20 percent from 2009 to 2010 (the difference between 2008 and 2009 was a three percent drop[*]).
- Non-group HMO experienced a large shift in covered members (388 in 2009 to 9,355 in 2010) and a large drop in average premium ($423 in 2009 to $179 in 2010). The increase in membership and resulting change in mix of benefits and underlying risk is caused by a carrier's reclassification of Healthy Kids from group in 2009 to non-group in 2010.

[*]2009 Supplemental Report

- The value for POS small group appears to have increased by 15 percent, however, the membership nearly doubled, which may have resulted in a change in risk in the underlying population that could be reflected in the premium levels.
- The majority of non-group members are enrolled in PPO products, and this segment saw a reduction in value equal to 8 percent. This is in addition to a 23 percent drop observed between 2008 and 2009*.
- The Indemnity plan type saw extensive variability with respect to average premiums and benefit richness often observed when analyzing plans with small membership populations. The small group premium decreased 53 percent while benefit richness decreased 84 percent. However, this category had a population change from 241 in 2009 to 1,341 in 2010 which may have caused a change in mix of members and underlying risk which could be reflected in the premium. Non-group Indemnity shows a 39 percent decrease in value.
- In many cases, the value of benefits decreased while premiums increased.
- In some cases the average premium went down: The EPO large group and small group premiums decreased, but were outpaced by decreases in benefits, resulting in an apparent reduction in value.
- The value for the large group PPO segment (representing 32% of covered members) decreased only 2 percent.

Average Premium and Adjusted Premium

With the actuarial value, average premiums can be adjusted based on the value of the benefits. This allows a more direct comparison of what different policies would cost if the value of the covered benefits were the same, however, factors such as changes due to age, health status, and other rating considerations have not been adjusted for. To the extent that those factors affect average premium levels, the adjusted premium values are not directly comparable. In some cases, membership is less than 0.5 percent and is shown as 0% due to rounding.

		Self-Insured*			Fully-Insured		
Plan Type	**Market Category**	**Percent of Members**	**Avg Premium**	**Adjusted Premium**	**Percent of Members**	**Avg Premium**	**Adjusted Premium**
HMO	Large Group	34%	$486	$535	25%	$439	$604
	Small Group	0%	$420	$486	23%	$410	$604
	Non-Group	No Membership Reported			3%	$179	$191
POS	Large Group	20%	$451	$552	2%	$580	$561
	Small Group	0%	$542	$551	2%	$371	$471
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	43%	$422	$536	18%	$413	$624
	Small Group	0%	$373	$517	6%	$415	$708
	Non-Group	No Membership Reported			11%	$269	$1,189
EPO	Large Group	1%	$308	$421	2%	$307	$505
	Small Group	No Membership Reported			6%	$371	$633
	Non-Group				0%	$468	$681
Indemnity	Large Group	2%	$560	$608	0%	$793	$844
	Small Group	No Membership Reported			0%	$340	$2,090
	Non-Group				1%	$201	$792
Total Members		340,838			298,250		

*A premium equivalent is provided for self-insured policyholders. Please see the Data Notes section for additional information regarding the calculation methodology.

Observations:

- Self-insured large group HMO premium is clearly higher than fully-insured ($486 versus $439), however, on an adjusted basis the fully insured premium is actually higher than self-insured.
- For large group PPO, the fully-insured premium is less expensive than the self-insured premium, but once benefits are adjusted for, the fully-insured premium is much higher than the self-insured premium.
- Within the PPO market category, fully insured premiums adjusted for benefit differences are inversely related to group size. Non-group and small group have a higher adjusted premium than large groups.
- EPO fully-insured adjusted average premium pattern is similar to the PPO category.

Health insurance benefits and medical care utilization by state and municipal employees are frequently considered unique. The following table shows the same calculations for each of these account types.

State and Municipal Account Comparison

Plan Type	Account Type	Percent of Members	Avg Premium*	Benefit Richness	Adjusted Premium*
HMO	State	4%	$430	0.76	$566
	Municipal	7%	$437	0.82	$530
	All Other Accounts	32%	$446	0.79	$565
POS	State	1%	$573	0.86	$662
	Municipal	5%	$468	0.79	$593
	All Other Accounts	6%	$424	0.86	$495
PPO	State	0%	$542	0.86	$631
	Municipal	0%	$468	0.59	$795
	All Other Accounts	39%	$398	0.61	$651
EPO	State	No Membership Reported			
	Municipal	0%	$390	0.67	$579
	All Other Accounts	4%	$349	0.60	$583
Indemnity	State	No Membership Reported			
	Municipal	1%	$598	0.91	$654
	All Other Accounts	1%	$292	0.29	$1,017
Total Members		639,088			

*A premium equivalent is provided for self-insured policyholders. Please see the Data Notes section for additional information regarding the calculation methodology.

Observations include:

- In 2009, benefit richness for State and Municipal HMO was reported as 0.98 and 0.97, respectively. In 2010, the benefit richness for State and Municipal is much lower, and now more in line with All Other Accounts.
- Although fewer State and Municipal covered members are enrolled in POS products, both the average premium and adjusted premium are substantially higher than for other POS policies.

MARKET CATEGORY

The market categories shown below with membership and loss ratios provide a more detailed breakdown of the summary market categories shown above. Separate tables exist for 2010 self-insured and fully-insured policies. A comparison of 2010 to 2009 is made in total.

All Members, by Insured Status and Market Category

Market Category	All Members	Loss Ratio	Self-Insured Members	Loss Ratio	Fully-Insured Members	Loss Ratio
Total Large Group	**75%**	**0.87**	**100%**	**0.88**	**47%**	**0.86**
Employers with 51-99 Employees	5%	0.89	1%	0.95	11%	0.89
Employers with >=100 Employees	65%	0.88	91%	0.89	34%	0.85
Employers through Qualified Trust	5%	0.79	None Reported		2%	0.80
Total Small Group	**18%**	**0.88**	**0%**	**1.08**	**38%**	**0.88**
Employers with 1 Employee	1%	0.97	None Reported		2%	0.97
Employers with 2-9 Employees	7%	0.85	0%	3.00	15%	0.85
Employers with 10-25 Employees	6%	0.87	0%	0.87	12%	0.87
Employers with 26-50 Employees	4%	0.91	0%	0.87	8%	0.91
Total Individual	**7%**	**0.67**			**15%**	**0.67**
Individual Policy	7%	0.66	None Reported		15%	0.66
Individual as Group Conversion	0%	1.84			0%	1.84
Grand Total	**639,088**	**0.87**	**340,838**	**0.88**	**298,250**	**0.85**

Overall Comparison – 2009 and 2010

The following table compares the membership distribution and loss ratios by market category for 2009 versus 2010.

	Percent of Members		Loss Ratio	
Market Category	**2009**	**2010**	**2009**	**2010**
Total Large Group	**75%**	**75%**	**0.92**	**0.87**
Employers with 51-99 Employees	6%	5%	0.90	0.89
Employers with >=100 Employees	63%	65%	0.94	0.88
Employers through Qualified Trust	6%	5%	0.84	0.79
Total Small Group	**20%**	**18%**	**0.92**	**0.88**
Employers with 1 Employee	1%	1%	1.07	0.97
Employers with 2-9 Employees	8%	7%	0.89	0.85
Employers with 10-25 Employees	7%	6%	0.90	0.87
Employers with 26-50 Employees	4%	4%	0.96	0.91
Total Individual	**5%**	**7%**	**0.68**	**0.67**
Individual Policy	5%	7%	0.66	0.66
Individual as Group Conversion	0%	0%	1.41	1.84
Grand Total	**542,829**	**639,088**	**0.91**	**0.87**

Observations:

- For all employer group market categories loss ratios were lower in 2010 than 2009, as was the aggregate loss ratio for all categories.
- The small group category of "1 Employee" continues to have a comparatively high loss ratio.
- The individual market continues to have a comparatively low loss ratio.
- Group conversion policies show a higher loss ratio for 2010 than for 2009. The conversion pool is small, decreasing in size, and prone to high loss ratios due to no medical underwriting.

DEDUCTIBLES

Information is collected on deductibles according to the dollar amount of the policy deductible. The deductible is the amount that the member pays before the health insurance carrier contributes to the cost of care. If the plan has more than one deductible, the highest level for medical services (i.e. the lowest deductible) within the network is used. Dollar amounts refer to individual deductibles, not family deductibles. Please note that one large carrier reported the out-of-network deductible in 2009 and reported the in-network deductible in 2010. Therefore year-to-year comparisons are not valid.

Summary comparison tables are shown below. A more detailed table is contained in Appendix A. Bold values represent the group (within each comparison) with the highest percentage of members where the value is at least two percent.

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	37%		**57%**	14%		**46%**	4%	21%
$1-250	2%		**4%**	0%		**3%**	0%	0%
$251-500	9%		**15%**	3%		**12%**	2%	0%
$501-750	9%		**10%**	9%		**10%**	**10%**	1%
$751-1,000	3%		**3%**	**3%**		**4%**	1%	0%
$1,001-1,500	11%		3%	**20%**		8%	22%	**23%**
$1,501-3,000	17%		4%	**33%**		11%	**40%**	27%
$3,001-5,000	7%		4%	**10%**		6%	**14%**	2%
$5,001-7,500	3%		1%	**5%**		1%	3%	**21%**
$7,501-10,000	1%		0%	**3%**		1%	**3%**	1%
$10,001+	0%		0%	1%		0%	0%	**4%**
Grand Total	**639,088**		**340,838**	**298,250**		**480,852**	**112,756**	**45,480**

Observations:

- The self-insured population benefits reflect lower deductibles than the fully-insured population
- Generally, the large groups have lower deductibles, while individuals and small groups have higher deductibles.
- The most common deductible for large groups is $0 and the most common deductible for small groups and individuals is in the $1,501-$3,000 range.
- The high percentage of members covered by a self-insured account without any deductible is partly the result of the state of NH employee plan and the benefit plans covering municipal employees. See chart below.

			Self-Insured		
Deductible	**All Self-Insured Members**		**State**	**Municipal**	**Other**
$0	57%		**100%**	89%	40%
$1-250	4%		0%	0%	**6%**
$251-500	15%		0%	6%	**20%**
$501-750	10%		0%	4%	**14%**
$751-1,000	3%		0%	0%	**4%**
$1,001-1,500	3%		0%	0%	**5%**
$1,501-3,000	4%		0%	1%	**5%**
$3,001-5,000	4%		0%	1%	**5%**
$5,001-7,500	1%		0%	0%	**1%**
Grand Total	**340,838**		**32,541**	**79,884**	**228,412**

CO-INSURANCE

Co-insurance is the percentage of the total claim that the member is responsible for paying. Co-insurance is paid after the deductible has been met. If the plan has more than one co-insurance level, the highest level for medical services (i.e. lowest member coinsurance %) within network is reported. Please note that one large carrier reported the out-of-network co-insurance percentage in 2009 and reported the in-network co-insurance in 2010. Therefore year-to-year comparisons are not valid.

Coinsurance	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
0%	66%		59%	**74%**		64%	**83%**	48%
5%	0%		0%	0%		0%	0%	0%
10%	9%		**15%**	3%		**12%**	2%	0%
15%	0%		1%	0%		1%	0%	0%
20%	21%		**21%**	**21%**		21%	14%	**43%**
25%	0%		0%	0%		0%	0%	0%
30%	2%		**3%**	1%		2%	0%	**6%**
35%	0%		0%	0%		0%	0%	0%
40%	0%		1%	0%		1%	0%	0%
50%	0%		0%	0%		0%	0%	**3%**
Total Members	**639,088**		**340,838**	**298,250**		**480,852**	**112,756**	**45,480**

Observations:

- Much of the non-group market has higher coinsurance percentages than large and small group, with 52 percent of individual members having to pay 20% or more co-insurance.

CO-PAYS

Co-pays represent the dollar amount of the highest office visit member contribution for services within network. The distribution of co-pay amounts is similar in 2010 to 2009, but with some increases and some decreases.

Copay	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	19%		16%	**23%**		17%	17%	**50%**
$5	7%		**13%**	0%		**9%**	0%	0%
$10	14%		**24%**	4%		**18%**	2%	10%
$15	8%		**8%**	7%		8%	**11%**	1%
$18	0%		0%	0%		0%	0%	0%
$20	19%		11%	**28%**		17%	24%	**28%**
$24	0%		0%	0%		0%	0%	0%
$25	11%		7%	**15%**		9%	**22%**	0%
$30	8%		**11%**	5%		**9%**	5%	3%
$35	2%		**4%**	1%		**3%**	0%	0%
$40	5%		4%	**7%**		5%	7%	**8%**
$45	1%		2%	0%		1%	0%	0%
$50	5%		2%	**9%**		4%	**12%**	0%
$55	0%		0%	0%		0%	0%	0%
$60	0%		0%	0%		0%	0%	0%
$65	0%		0%	0%		0%	0%	0%
$70	0%		0%	0%		0%	0%	0%
$75	0%		0%	0%		0%	0%	0%
Total Members	**639,088**		**340,838**	**298,250**		**480,852**	**112,756**	**45,480**

	All Members	
Copay	**2009**	**2010**
$0	18%	19%
$5	8%	7%
$10	20%	14%
$15	12%	8%
$18	0%	0%
$20	19%	19%
$24	0%	0%
$25	7%	11%
$30	5%	8%
$35	2%	2%
$40	6%	5%
$45	0%	1%
$50	5%	5%
$55	0%	0%
$60	0%	0%
$65	0%	0%
$70	0%	0%
$75	0%	0%
Total Members	**542,829**	**639,088**

Observations:

- There appears to be shifting to higher co-pays with decreases in the number of members with $10 and $15 co-pays and increases in the number of members with $25 and $30 co-pays.

COVERED BENEFITS

Coverage for benefits is based on whether the policy provides coverage at the level described in the Supplemental Report bulletin. Definitions are provided in Appendix B for all 26 benefit categories included in the Supplemental Report filing. A few of these categories had none or very few members without coverage, but all are listed in the table below.

Covered benefits are subject to greater reporting variation. This variation is due to differences in how carriers interpret policy coverage and the definition of the benefits described in the bulletin.

Members appearing to be without coverage for a particular benefit may obtain coverage for that benefit through a mechanism other than the primary insurance carrier. Examples of this include mental health benefits and prescription drug coverage provided by an organization external to the employer or insurance carrier.

Detailed Benefit Category Table:

Coverage Category	Covered	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
Ambulance Services	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%
Audiology Screening of Newborns	Yes	97%		97%	96%		98%	99%	78%
	No	3%		3%	4%		2%	1%	22%
Blood and Blood Products	Yes	78%		66%	91%		71%	99%	98%
	No	22%		34%	9%		29%	1%	2%
Case Management Programs	Yes	100%		100%	100%		100%	100%	99%
	No	0%		0%	0%		0%	0%	1%
Chiropractic Services	Yes	91%		97%	84%		97%	90%	35%
	No	9%		3%	16%		3%	10%	65%
Durable Medical Equipment	Yes	100%		100%	100%		100%	100%	98%
	No	0%		0%	0%		0%	0%	2%
Emergency Room Services	Yes	100%		100%	99%		100%	99%	98%
	No	0%		0%	1%		0%	1%	2%
Family Planning Services	Yes	87%		87%	88%		87%	98%	61%
	No	13%		13%	12%		13%	2%	39%
Habilitative Services	Yes	53%		54%	52%		56%	48%	30%
	No	47%		46%	48%		44%	52%	70%
Hearing Aids	Yes	61%		52%	72%		57%	72%	81%
	No	39%		48%	28%		43%	28%	19%
Home Health Care	Yes	99%		100%	98%		100%	99%	87%
	No	1%		0%	2%		0%	1%	13%
Hospice	Yes	78%		68%	90%		72%	98%	93%
	No	22%		32%	10%		28%	2%	7%
Hospitalization	Yes	99%		100%	98%		100%	99%	87%
	No	1%		0%	2%		0%	1%	13%
Infertility Services	Yes	59%		64%	53%		60%	57%	51%
	No	41%		36%	47%		40%	43%	49%
Medical Food	Yes	96%		95%	97%		96%	99%	84%
	No	4%		5%	3%		4%	1%	16%
Mental Health and Substance Abuse	Yes	77%		67%	88%		72%	98%	81%
	No	23%		33%	12%		28%	2%	19%
Nutritional Services	Yes	73%		61%	86%		67%	93%	79%
	No	27%		39%	14%		33%	7%	21%
Outpatient Hospital Services and Surgery	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%
Outpatient Laboratory and Diagnostic Services	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%

Coverage Category	Covered	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
Outpatient Rehabilitation Services	Yes	99%		100%	97%		100%	99%	84%
	No	1%		0%	3%		0%	1%	16%
Pregnancy and Maternity Services	Yes	99%		100%	97%		100%	99%	82%
	No	1%		0%	3%		0%	1%	18%
Preventive Services	Yes	82%		73%	92%		77%	98%	91%
	No	18%		27%	8%		23%	2%	9%
Prescription Drugs	Yes	89%		80%	99%		86%	99%	100%
	No	11%		20%	1%		14%	1%	0%
Skilled Nursing Facility	Yes	89%		83%	95%		86%	99%	96%
	No	11%		17%	5%		14%	1%	4%
Transplants	Yes	100%		99%	100%		99%	100%	99%
	No	0%		1%	0%		1%	0%	1%
Well Child and Immunization Services	Yes	92%		89%	96%		91%	99%	91%
	No	8%		11%	4%		9%	1%	9%

Sometimes fewer fully-insured or small group members are without coverage for a particular benefit. This is probably due to NH laws for mandated benefits. Larger employers are more likely to be self-insured and have more flexibility to negotiate which benefits will be covered under their policy.

CARRIER MEMBERSHIP DISTRIBUTION

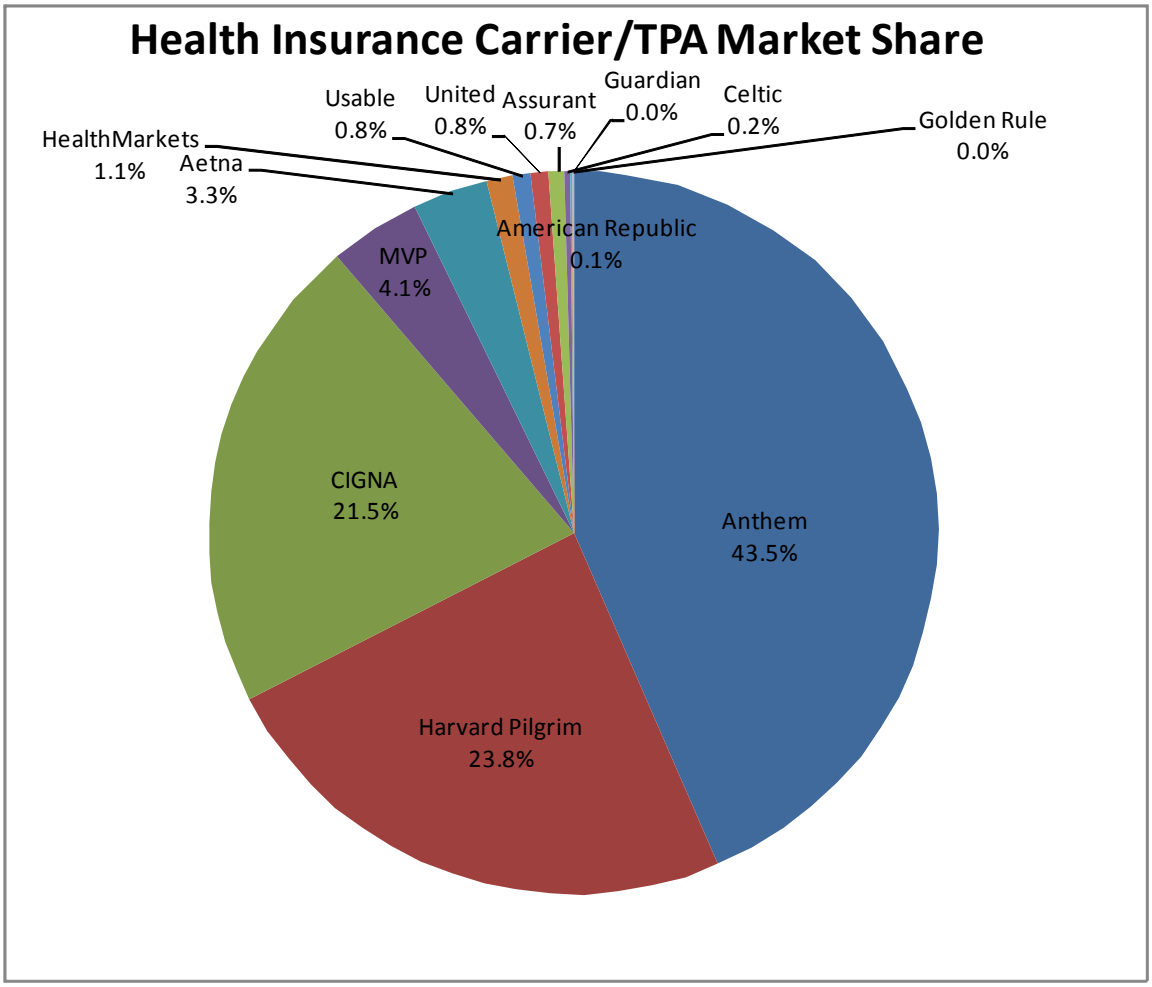
Data submitted for the Supplemental Report is based on policyholder. The data include insured members who reside outside of NH if covered under a NH policy. These data include self-funded accounts.

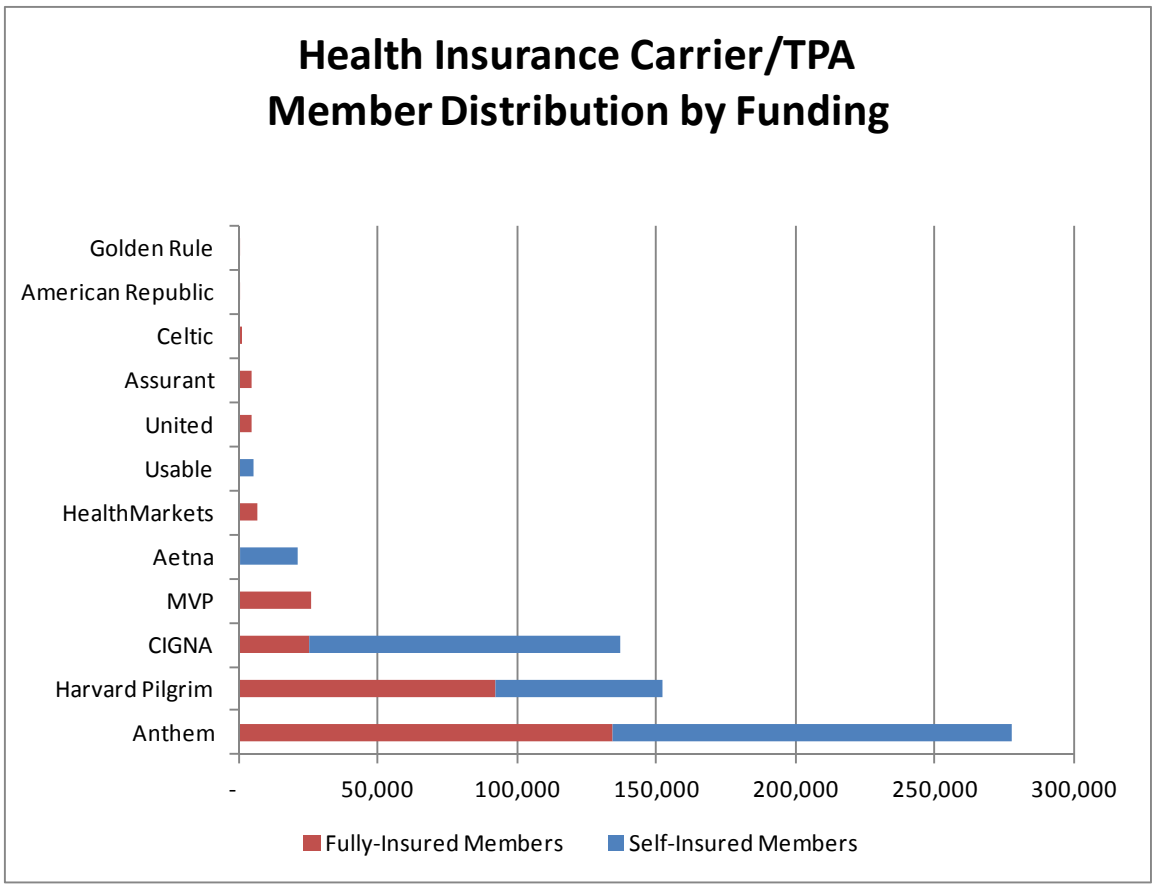
The following companies have been grouped into one "family" company name for the tables below:

- Anthem includes: Anthem Health Plans of NH and Matthew Thornton, but does not include FEP (approximately 30,000 members) nor national accounts (about 10,000 members)
- Assurant includes: Time Life Insurance Company and John Alden Life Insurance Company
- CIGNA includes: CIGNA HealthCare of NH, Connecticut General Life Insurance Company, and Great West Life & Annuity Insurance Company
- Harvard Pilgrim includes: Harvard Pilgrim HealthCare NE, HPHC, Harvard Pilgrim Health Care, and Health Plans, Inc.
- HealthMarkets includes: The Chesapeake Life Insurance Company and The Mega Life and Health Insurance Company
- MVP includes: MVP Health Insurance Company of NH and MVP Health Plan of NH

Based on the Supplemental Report submission, the distribution of members by carrier is shown in the chart below:

Health Insurance Carrier/TPA	Self-Insured Members	Fully-Insured Members	Total Members	Percent of Total
Aetna	20,427	821	21,248	3.3%
American Republic	-	504	504	0.1%
Anthem	143,704	134,242	277,946	43.5%
Assurant	-	4,791	4,791	0.7%
Celtic	-	1,552	1,552	0.2%
CIGNA	111,541	25,732	137,273	21.5%
Guardian	-	83	83	0.0%
Golden Rule	-	237	237	0.0%
Harvard Pilgrim	60,078	92,306	152,384	23.8%
HealthMarkets	-	7,087	7,087	1.1%
MVP	-	25,948	25,948	4.1%
United	-	4,949	4,949	0.8%
Usable	5,088	-	5,088	0.8%
Total	**340,838**	**298,250**	**639,088**	**100.0%**


Health Insurance Carrier/TPA Market Share
Usable 0.8%
United 0.8%
Assurant 0.7%
Guardian 0.0%
Celtic 0.2%
Golden Rule 0.0%
HealthMarkets 1.1%
Aetna 3.3%
American Republic 0.1%
MVP 4.1%
CIGNA 21.5%
Anthem 43.5%
Harvard Pilgrim 23.8%


Health Insurance Carrier/TPA
Member Distribution by Funding
Golden Rule
American Republic
Celtic
Assurant
United
Usable
HealthMarkets
Aetna
MVP
CIGNA
Harvard Pilgrim
Anthem
-
50,000
100,000
150,000
200,000
250,000
300,000
Fully-Insured Members
Self-Insured Members

SUPPLEMENTAL REPORT HISTORY

The first round of supplemental report filings occurred on May 1, 2002, and included data from calendar year 2001. The first data submission applied only to licensed non-profit health service corporations and licensed health maintenance organizations. All other licensed health carriers filed in 2003. In 2006, the department substantially revised the bulletin that describes how data need to be submitted to the NHID. For this reason, the 2006 report cannot be compared to prior submissions. The 2007 bulletin had minor changes, but included a separate variable for self-insured vs. fully-insured data. This separation allows greater insight into the market dynamics of the differing policy types. The 2009 bulletin clarified that out-of-state employer's branch location in NH shall be considered a New Hampshire employer, and the carrier/TPA shall submit data for all members who are employed at that branch location.

DATA COLLECTED

The Supplemental Report data collection applies to all health insurance companies and health maintenance organizations licensed in New Hampshire. All third party administrators (TPAs) licensed or registered in New Hampshire must submit data.

Data submitted by TPAs must comply with instructions in order to compare self-insured costs to what is experienced with underwritten insurance. To compare self-insured to fully-insured, a premium equivalent is calculated, based on the total cost to the employer including special programs such as disease management.

Data are submitted to the NHID by stop loss companies as a part of the Supplemental Report data collection process, but are not reported here. The membership covered under these polices are tracked through the TPA, as is the overall health insurance premium equivalent and the corresponding medical claims.

Carriers meeting the de minimis exemption do not submit data that are tabulated in this report. Carriers that write less than $250,000 in accident and health insurance premiums in New Hampshire are no longer required to submit a null report. TPAs with fewer than 2,400 covered life months must file a null report with the NHID.

Data are collected for New Hampshire policies, including when an organization has "bricks and mortar" in New Hampshire. For example, assume a TPA administers a health benefit plan. This plan covers a New Hampshire employer and there are 250 lives associated with this employer's plan of which 100 of the 250 lives are Massachusetts residents, and the remaining 150 lives are New Hampshire residents. This TPA is required to report all lives, regardless of the state of residency, covered through this plan as they are all associated with a NH employer's health benefit plan.

In another example, assume a TPA administers a health benefit plan. This plan is for a Massachusetts employer and there are 500 lives associated with this employer's plan and the employer has no facilities in NH. Half of these lives are New Hampshire residents

whose principal place of employment is in Massachusetts. This TPA would not be required to report these lives as none of the 500 lives are associated with a NH employer's health benefit plan. The same principles apply to fully-insured policies. Policies issued to NH employers or that cover members who have a work location in New Hampshire should be reported in the New Hampshire Supplemental Report.

For an explanation of the data fields used in the supplemental report, please see the Supplemental Report bulletin on the NHID website that describes how the data must be submitted to the NHID:
http://www.nh.gov/insurance/lah/documents/sup-rep_bul_11.pdf.

DATA NOTES

This version of the 2010 Supplemental Report was produced using methods developed by the NHID and by Compass Health Analytics, Inc. working under a contract with the NHID.

Supplemental Report data are submitted to the NHID by July 15 of each year for premium billed and claims with a date of service during the prior calendar year. The length of time after the incurred period is needed in order to adequately capture data on a "claims paid" basis, which may take several months for the provider to submit the claim, the carrier to process the claim, and the data to be loaded in reporting databases.

Upon receiving data from the carrier, the NHID analyzes the submission and provides a summary report back to the carrier. This quality assurance process takes place to confirm that what is submitted by the carrier is reasonable and without major errors that occasionally develop during a data submission process. Additionally, questions are presented to the carriers when apparent anomalies are discovered upon examination of the submitted data. As a result, some carriers resubmit data to correct errors, however not all anomalies and data errors are eliminated with this process. No further auditing of the data takes place.

Many of the statistics in this report are based on membership. Membership numbers are calculated averages based on member months. If a member was covered for twelve months, that member is reported to the NHID with twelve member months and represents one complete member. If a member was only insured for half the year, six months are reported and the membership value is 0.5. This method of averaging allows the NHID to provide comparable numbers of members, when in practice the actual number of members fluctuates throughout the year. Additionally, many individuals may be insured for only part of the year due to moving in or out of state, changing employers, or becoming uninsured. The averaging mechanism avoids overestimating the number of persons insured by counting membership on a pro-rated basis. As members can be counted on a partial basis, summary totals may differ due to rounding errors.

"Loss ratio" is the term that is used to assess what percentage of the premium is paid out for medical claims. Loss ratio is calculated using the data submitted in the Supplemental

Report by dividing the total medical and pharmacy claims dollars by the total premium dollars. This calculation also takes place for self-funded insurance using a premium equivalent.

Third party administrators (TPAs) calculate an earned premium equivalent based on the contribution rates established for the coverage being reported. These premium equivalents include all funds collected by the TPA from the account in relation to the TPA's administration of the group's health plan. The funds include provisions for claims, administration, stop-loss insurance, TPA's profit margins, commissions, wellness programs, network fees, and disease management programs.

A loss ratio of 0.85 means that 85 cents of every premium dollar is used to cover the cost of medical claims. The difference between 0.85 and 1.0 in this example (equal to 15 cents of every premium dollar) is the amount that covers carrier administrative costs and profit, but does not include all factors that affect carrier profitability.

Average premiums are provided in this report. These averages are calculated by the NHID on a per member per month basis. This allows comparability, but the average premiums will not reflect the actual premium paid by any particular enrollee. This is due to several factors related to the way premiums are calculated, including the application of rating factors, the employee/employer contributions, and premium tiering for coverage types including family, couple, and individual.

The actuarial value is a factor representative of the relative value of the benefits being reported against a standardized set of benefits. RSA 420-G:4 I (c) requires carriers to calculate a health coverage plan rate for each of its coverage options. The New Hampshire Small Employer Reinsurance Pool developed four benefit plans that ceding carriers used to adjudicate claims (indemnity, PPO, POS, and HMO). Carriers calculate the health coverage plan rate for these four plans (called standardized plans). Then, for each reported coverage, the carrier calculates the health coverage plan rate. The actuarial value is the ratio of the health coverage plan rate for each reported coverage to the health coverage plan rate for the corresponding standardized plan. As part of the quality assurance process, some actuarial values were identified as anomalies (outside the range of expected values). Questions were posed to carriers providing those anomalous values, resulting in some corrections, however some seemingly anomalous actuarial values remain in the data used for this report.

Benefit richness is a ratio of the unadjusted premium to the adjusted premium (premium divided by the actuarial values submitted by the carriers). When aggregating data, the benefit richness is the ratio of the sum of the unadjusted premiums divided by the sum of the adjusted premiums.

During the quality assurance process, a large increase in membership was observed in the Non-group HMO segment when comparing 2009 and 2010. The explanation provided by the carrier is that Healthy Kids was classified as group in 2009 and was changed to non-group in 2010.

One major carrier changed how they report deductible and coinsurance levels. In 2009, they reported out-of-network deductible and coinsurance levels. In 2009, they reported in-network deductible and coinsurance levels. Caution should be exercised when comparing the 2009 and 2010 distribution of members by deductible and coinsurance level.

Due to the unique nature of these products, data related to policies for stoploss, student coverage, blanket insurance, and the high risk pool was excluded from this report.

Like any data collection tool, the Supplemental Reporting tool has limitations. These limitations are not unlike any that are to be expected with survey data. Therefore, while the NHID believes this report accurately represents the health insurance marketplace in New Hampshire, we believe that the data include a degree of error that cannot be eliminated with this type of reporting process.

Comments or questions should be directed to tyler.brannen@ins.nh.gov.

Appendix A - Detailed Distribution of Members by Deductible

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	37%		**57%**	14%		**46%**	4%	21%
$50	0%		0%	0%		0%	0%	0%
$60	0%		0%	0%		0%	0%	0%
$75	0%		0%	0%		0%	0%	0%
$100	1%		1%	0%		1%	0%	0%
$125	0%		0%	0%		0%	0%	0%
$150	1%		1%	0%		1%	0%	0%
$175	0%		0%	0%		0%	0%	0%
$200	1%		2%	0%		1%	0%	0%
$250	6%		**9%**	2%		**7%**	2%	0%
$275	0%		0%	0%		0%	0%	0%
$300	2%		**3%**	0%		2%	0%	0%
$321	0%		0%	0%		0%	0%	0%
$325	0%		0%	0%		0%	0%	0%
$350	1%		**2%**	0%		1%	0%	0%
$400	1%		1%	0%		1%	0%	0%
$450	0%		0%	0%		0%	0%	0%
$500	9%		**9%**	9%		9%	**10%**	1%
$525	0%		0%	0%		0%	0%	0%
$550	0%		0%	0%		0%	0%	0%
$575	0%		0%	0%		0%	0%	0%
$600	0%		0%	0%		0%	0%	0%
$650	0%		0%	0%		0%	0%	0%
$666	0%		0%	0%		0%	0%	0%
$700	0%		0%	0%		0%	0%	0%
$750	2%		**3%**	2%		**3%**	1%	0%
$800	0%		0%	0%		0%	0%	0%
$825	0%		0%	0%		0%	0%	0%
$850	0%		0%	0%		0%	0%	0%
$900	0%		0%	1%		1%	0%	0%
$901	0%		0%	0%		0%	0%	0%
$1,000	10%		2%	**19%**		7%	**21%**	19%
$1,100	0%		0%	0%		0%	0%	0%
$1,150	0%		0%	0%		0%	0%	0%
$1,200	0%		1%	0%		1%	0%	0%
$1,250	1%		0%	1%		0%	0%	4%
$1,300	0%		0%	0%		0%	0%	0%
$1,350	0%		0%	0%		0%	0%	0%
$1,400	0%		0%	0%		0%	0%	0%
$1,500	4%		1%	**8%**		3%	**11%**	3%

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$1,525	0%		0%	0%		0%	0%	0%
$1,600	0%		0%	0%		0%	0%	0%
$1,650	0%		0%	0%		0%	0%	0%
$1,700	0%		0%	0%		0%	0%	0%
$1,750	0%		0%	0%		0%	0%	0%
$1,800	0%		0%	0%		0%	0%	0%
$1,834	0%		0%	0%		0%	0%	0%
$1,875	0%		0%	0%		0%	0%	0%
$1,950	0%		0%	0%		0%	0%	0%
$2,000	8%		1%	**16%**		6%	**18%**	6%
$2,050	0%		0%	0%		0%	0%	0%
$2,100	0%		0%	0%		0%	0%	0%
$2,150	0%		0%	0%		0%	0%	0%
$2,200	0%		0%	0%		0%	0%	0%
$2,250	0%		0%	0%		0%	0%	0%
$2,300	0%		0%	0%		0%	0%	0%
$2,400	0%		0%	0%		0%	0%	0%
$2,450	0%		0%	0%		0%	0%	0%
$2,500	4%		0%	**9%**		2%	11%	**16%**
$2,550	0%		0%	0%		0%	0%	0%
$2,600	0%		0%	0%		0%	0%	1%
$2,625	0%		0%	0%		0%	0%	0%
$2,700	0%		0%	0%		0%	0%	0%
$2,800	0%		0%	0%		0%	0%	0%
$2,850	0%		0%	0%		0%	0%	0%
$3,000	6%		3%	**9%**		5%	**12%**	1%
$3,050	0%		0%	0%		0%	0%	0%
$3,075	0%		0%	0%		0%	0%	0%
$3,200	0%		0%	0%		0%	0%	0%
$3,375	0%		0%	0%		0%	0%	0%
$3,400	0%		0%	0%		0%	0%	0%
$3,450	0%		0%	0%		0%	0%	0%
$3,500	0%		0%	1%		0%	1%	0%
$3,600	0%		0%	0%		0%	0%	0%
$3,750	0%		0%	0%		0%	0%	1%
$4,000	1%		0%	1%		1%	1%	0%
$4,200	0%		0%	0%		0%	0%	0%
$4,500	0%		0%	0%		0%	0%	0%
$4,800	0%		0%	0%		0%	0%	0%
$4,950	0%		0%	0%		0%	0%	0%

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$5,000	3%		1%	**5%**		1%	3%	**20%**
$5,100	0%		0%	0%		0%	0%	0%
$5,150	0%		0%	0%		0%	0%	0%
$5,400	0%		0%	0%		0%	0%	0%
$5,450	0%		0%	0%		0%	0%	0%
$5,600	0%		0%	0%		0%	0%	0%
$5,650	0%		0%	0%		0%	0%	0%
$6,000	0%		0%	0%		0%	0%	0%
$6,150	0%		0%	0%		0%	0%	0%
$6,400	0%		0%	0%		0%	0%	0%
$7,500	1%		0%	**3%**		1%	**3%**	1%
$10,000	0%		0%	1%		0%	0%	**4%**
$12,000	0%		0%	0%		0%	0%	0%
$15,000	0%		0%	0%		0%	0%	0%
$20,000	0%		0%	0%		0%	0%	0%
$24,000	0%		0%	0%		0%	0%	0%
$25,000	0%		0%	0%		0%	0%	0%
Total Members	**639,088**		**340,838**	**298,250**		**480,852**	**112,756**	**45,480**

Appendix B- Benefit Category Descriptions

Ambulance Service	Includes: ambulance transportation.
Audiology Screening for Newborns	Includes: covered for one screening and one confirming screening.
Blood and Blood Products	Includes: fees associated with the collection or donation of blood or blood products, all cost recovery expenses for blood, blood derivatives, components, biologics, and serums to include autologous services and albumin.
Case Management Program	Includes: available for medically complex and costly services.
Chiropractic Services	Includes chiropractic services.
Durable Medical Equipment (DME)	Includes: nebulizers, peak flow meters, and diabetes glucose monitoring equipment.
Emergency Room	Includes: emergency room treatment.
Family Planning Services	Full range of services including: Counseling services and patient education; examination and treatment by medical professionals; laboratory examinations and tests; medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception; and infertility services, including sterilization reversals.
Habilitative Services	Includes: coverage for children 0-19 years of age for treatment of congenital and genetic birth defects.
Hearing Aids	Includes: coverage for persons 0-18 years of age, including hearing aid for each hearing-impaired ear, every 36 months.
Home Health Care	Includes: coverage as an alternative to otherwise covered services in a hospital or other related institution.
Hospice	Includes: coverage same as Medicare, including nursing care, medical social services, physicians' services, counseling services, short-term inpatient care, medical appliances and supplies, home health aide services, physical therapy, occupational therapy, speech-language pathology, and other items and services.
Hospitalization	Includes: unlimited (includes detoxification)
Infertility Services	Includes: coverage for services obtained after diagnosis of infertility (excludes in vitro fertilization)
Medical Food	Includes: for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis or treatment in the field of metabolic disorders
Mental Health and Substance Abuse	Includes: when delivered through a managed care system for 60 inpatient days with partial hospitalization traded on

	a 2 to 1 basis and unlimited outpatient visits
Nutritional Services	Includes: six visits per year for cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease.
Outpatient Hospital Services & Surgery	Includes: outpatient hospital services and surgery.
Outpatient Laboratory & Diagnostic Services	Includes: outpatient laboratory and diagnostic services.
Outpatient Short-Term Rehabilitative Services	Includes: physical therapy, speech therapy, and occupational therapy.
Pregnancy and Maternity	Includes: pregnancy and maternity.
Prescription Drugs (Rx)	Includes: prescriptions available on an open formulary with coverage at least the generic drug equivalent amount when the brand name drug is prescribed.
Preventive Services	Includes: services recommended by the U.S. Preventive Services Task Force and other services required to be a Federally Qualified HMO, including: a broad range of voluntary family planning services; services for infertility; well-child care from birth; periodic health evaluations for adults; eye and ear examinations for children through age 17, to determine the need for vision and hearing correction; pediatric and adult immunizations in accord with accepted medical practice.
Skilled Nursing Facility	Includes: 100 days as an alternative to otherwise covered care in a hospital or other related institution.
Transplants	Includes: for bone marrow, cornea, kidney, liver, lung, heart, pancreas, and pancreas/kidney transplants.
Well Child & Immunization Benefits	Includes: for children 0 – 13 years of age.